DOCUMENT RESUME

ED 385 082 EC 304 115

AUTHOR Villegas, Orlando; And Others
TITLE Understanding Attention Deficit Disorders.
INSTITUTION Oakland County Schools, Pontiac, Mich. Div. of Special Education.
PUB DATE Mar 95
NOTE 25p.
AVAILABLE FROM Oakland Schools, Psychology and Learning Clinic, 2100 Pontiac Lake Rd., Waterford, MI 48328-2735 (1-5 copies, $3 each; 6-10 copies, $2.50 each; 11 or more copies, $1.75 each).
PUB TYPE Guides - Non-Classroom Use (055)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Attention Deficit Disorders; *Clinical Diagnosis; Disability Identification; Drug Therapy; *Hyperactivity; *Intervention; *Symptoms (Individual Disorders)

ABSTRACT

This booklet provides basic information regarding attention deficit hyperactivity disorders (ADHD), in their separate modalities, with hyperactivity, impulsivity, and inattention. Explanations are offered concerning short attention span, impulsive behavior, hyperactivity, and beginning new activities before completing the previous one. Theories regarding the causes of ADHD are noted, and it is claimed that children with ADHD do not outgrow it. Some of the symptoms are modified by age, but attentional problems, impulsive tendencies, and social adjustment difficulties usually stay. An overview of the diagnostic process is provided, including intellectual and neurological evaluations. Two treatment approaches that have had the most effective results are considered: behavior/cognitive interventions (providing consistency, single directions, rule enforcement, and clear directions) and medication. (SW)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED 385 082

understanding

attention deficit disorders

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☑ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

Orlando Villegas, M.A.
Thomas Harwood, Sp.A.
Richard Brozovich, Ph.D.

March 1995

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

R. Brozovich

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

EC 304 115

BEST COPY AVAILABLE

THE AUTHORS

Orlando L. Villegas, M.A., is a limited licensed psychologist currently in practice with Triad Mental Health Services in Birmingham, Michigan and with Southwest Detroit Community Mental Health Services. He is the author of four booklets about Attention Deficit Hyperactivity Disorder.

Richard W. Brozovich, Ph.D., is the director of the Psychology and Learning Clinic at Oakland Schools. Dr. Brozovich participated in developing guidelines to assist school psychologists and school social workers in Oakland County who are involved in the assessment of students with ADHD.

Thomas Harwood, Sp.A., is the behavior management consultant at Oakland Schools. Mr. Harwood has served as a consultant to the Michigan Department of Education, and more recently, contributed to the establishment of the State Board of Education guidelines for behavioral interventions within special education. He is currently serving as a member of an established task force for the Michigan Department of Education in the development of recommendations for serving the Attention-Deficit Hyperactivity Disorder student in the general education and/or special education setting.

BEST COPY AVAILABLE

understanding
attention deficit disorders

Orlando Villegas, M.A.
Thomas Harwood, Sp.A.
Richard Brozovich, Ph.D.

Oakland Schools
Division of Special Education
Psychology and Learning Clinic
Instructional Services Department
2100 Pontiac Lake Road
Waterford, MI 48328

ACKNOWLEDGEMENTS

The document was developed as part of a series of booklets that address the needs of the child with ADD/ADHD and the parents and teachers who work to support this child/student. The booklets were printed by the Oakland Schools Division of Special Education with the support of Dr. Regis J. Jacobs, Director of Special Education

A total of 2,000 copies of this booklet were printed and distributed to ancillary staff in the local districts throughout Oakland County. Additional copies can be obtained by contacting the Oakland Schools Psychology Clinic at (810) 858-1951. The cost for copies of this document are:

1 - 5	$3.00 each
6 - 10	$2.50 each
11 or more copies	$1.75 each

This expense covers the cost of printing and handling.

This document may be reproduced and disseminated to all interested parties.

understanding
attention deficit disorders

Once upon a time, before special education was established, there was a group of children at school who were not learning as well as the other students. At this time, some parents thought that these children were lazy or unmotivated to learn. Other parents thought that these children needed some discipline. Disciplinary means were implemented, rewards and punishment were offered to increase motivation for school work...but, they did not change...they were not learning as well as the other students.

Some people wondered if these children had a real problem. Many years went past and there were many arguments and discussions between those who believed and those who did not believe these students had special learning difficulties. Finally, research proved the existence of what we now call learning disabilities.

Since the implementation of special education many of the students who had been struggling trying to learn have found life easier. Before, it was like walking in the darkness, with people calling them lazy or stupid. The broad acceptance of learning disabilities changed parent and teacher attitudes toward children who were not learning as well as other students.

There is another group of students who are not learning as well as other students. They are not learning disabled. Most of them are smart, sometimes they get good grades and sometimes they get poor grades. Sometimes they are likeable and sometimes we do not want to get near them. Sometimes they make their parents feel really proud and many times the parents feel very frustrated.

These students are experiencing what is called Attention Deficit Hyperactivity Disorder (ADHD). Despite the many books and articles regarding this disorder, the radio and television talk-shows approaching this problem, and the United States Department of Education memo stating mandatory services for ADHD students, there are many people who still do not know about or refuse to accept the existence of this disorder.

This booklet intends to provide basic information regarding Attention Deficit Hyperactivity Disorders, in their separate modalities, with hyperactivity, impulsivity, and inattention. It is important for those who have to deal with children who experience these disorders to learn as much as they can to help in the treatment process. Treatment for these children is not an individual treatment, it is a family treatment. If family members do not cooperate, chances of improving the disruptive behavior of these children are minimal. Parents must acquire knowledge and skills if they hope to use successful methods to manage behavior. Teachers also have to become skilled in working with students with attention disorders since at least one out of twenty students show symptoms of these disorders.

Scientific literature is very important and valuable, but more often than not it is boring. In this booklet you will find practical information. In order to keep the booklet brief and practical, we do not reference any sources in the booklet. However, we list some publications at the end of the booklet for those interested in additional reading material.

We dedicate this booklet to the parents and teachers who try to learn about and help these children. We would like to include in this dedication those who are skeptical about this diagnosis of ADHD. We hope they will keep an open mind and this booklet will encourage them to seek more ADHD information.

concept definition

Professionals use three terms to define attention deficit disorders. The first term is Attention Deficit Hyperactivity Disorder (ADHD - HI), Predominantly Hyperactive-Impulsive type. The second term is reserved for those children with attentional deficits but without notable hyperactivity. We call it Attention Deficit Hyperactivity Disorder (ADHD - I), Predominantly Inattentive type. The third term is Attention Deficit Hyperactivity Disorder (ADHD - C), Combined type.

symptoms

As we mentioned before, many people talk about ADHD. The term "hyperactive children" has become very popular. In our opinion the term has been overused. It is easy to find cases of children who display disruptive behavior in the classroom who were "diagnosed" as hyperactive, without any formal evaluation by a professional. We have to remember that ADHD children can be disruptive in the classroom, but not all disruptive children are ADHD children.

A child may display overactive behavior for many reasons other than the presence of an ADHD. Depression and anxiety may cause overactive and disruptive behavior in children. Learning disabilities and low self-esteem may be underlying this overactive and disruptive behavior.

The only way to know if we are dealing with a true ADHD child or with a child suffering from other problems is by having a qualified professional complete the diagnostic process that will be described later on in this booklet.

The basic symptoms in ADHD children are:

1. Short attention span

   These children have a hard time when they are requested to pay attention. They do not show any attention problems if they "want" to pay attention. They have no problems paying attention to something that is funny, or just interesting. This is why they can watch TV or play video games for hours without interruption. This attention problem is mostly evidenced in the classroom setting. ADHD children are unable to sustain attention on what the teacher is showing, writing on the board or on their seatwork.

2. Impulsive behavior

   These children usually act before thinking. It is usually not an intentionally disruptive behavior. They have a difficult time inhibiting behavior. This impulse control deficiency seems to have a biological origin. This means that they react impulsively without stopping to think about the consequences of the behavior.

3. Hyperactivity

   These children are always on the go, endless talking, running, getting easily bored because "they do not have anything to do."

4. Beginning new activities before they have completed the previous one

   There are other symptoms, however, the ones listed above are the most common signs found in ADHD children.

For those children with ADHD - I , the common symptoms are:

1. Short attention span (as described above)

2. Difficulties in social interaction. Usually quiet, without attempting to interact in groups. Due to these characteristics, teachers usually do not identify these children as problematic until they get poor grades.

Along with these common symptoms ADHD children may show low self-esteem and they are easily frustrated. At times, some ADHD children are overly aggressive.

How do parents and teachers react to ADHD children?

The word "frustration" may very well represent what parents and teachers experience when dealing with ADHD children. Parents and teachers complain about the irregular behavior of these children, how difficult it is to find the right technique to control their behavior, and their erratic performance. Many parents state that they have tried everything without positive results, including sophisticated techniques found in scientific books.

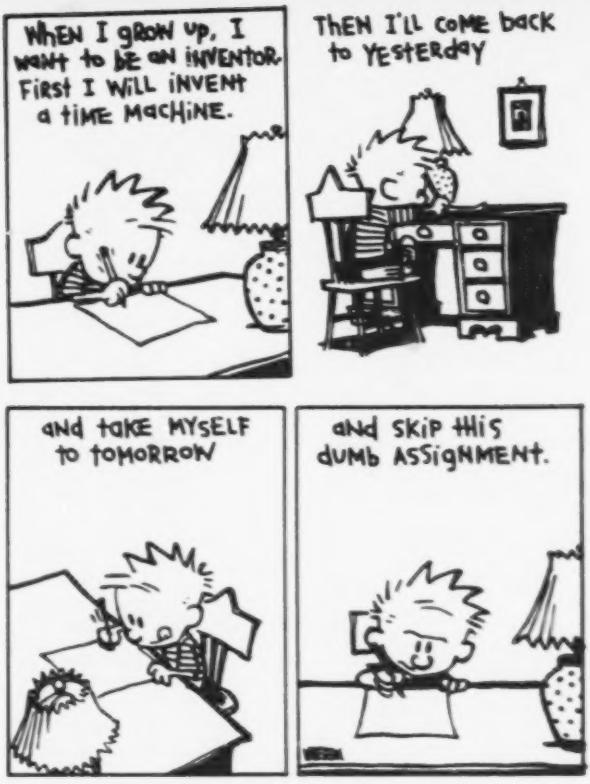
If parents and teachers do not relate the disruptive behavior in these children to the ADHD condition, they may react as if the behavior were intentional and will take it personally as if the child is trying to bother him/her. Denial of the ADHD condition creates more frustration. Some parents think it is a matter of discipline and punishment becomes a central issue every day. As a result, these children spend more time grounded than learning alternative behaviors. All the punishment does not provide positive results and the frustration builds up to intolerable limits.

What are the causes of ADHD:

There are many theories regarding the origin of these disorders, however, as of today we do not know the cause of ADHD. Studies reveal that these problems run in families. It is common to find that the father or mother or uncle or aunt of an ADHD child presents similar symptoms.

No single theory is fully accepted as an explanation about the origin of ADHD. However, there are two facts that are usually accepted. The first is related to the biological origin of these disorders. This means that ADHD children were born with these conditions. ADHD is not the result of child rearing methods or family climate. Certainly environment plays a very important role in the manifestation of these disorders but environment does not create the problem. The second fact is related to diet. Studies indicate that diet does not result in ADHD. Substances such as sugar, artificial colorants and artificial flavor have been blamed for these disorders. There is no evidence that supports diet as a cause. It is important to point to the fact that some allergic reactions may also mimic ADHD symptoms.

Calvin and Hobbes reproduced with permission of Universal Press Syndicate. Copyright Watterson, 1989.


WHEN I GROW UP, I WANT TO BE AN INVENTOR. FIRST I WILL INVENT A TIME MACHINE.
THEN I'LL COME BACK TO YESTERDAY
AND TAKE MYSELF TO TOMORROW
AND SKIP THIS DUMB ASSIGNMENT.

ADHD children growing up:

ADHD children often do not outgrow these disorders. Some of the symptoms are modified by age, however, attentional problems, impulsive tendencies, and social adjustment difficulties usually stay.

More than one half of ADHD children learn effective means to deal with their symptoms. As adults they still experience them but they know how to manage work and social interaction with minimal disruption. In cases where there is not any form of treatment provided and the ADHD child never learned about his/her disorder, the chances are that the symptoms may disrupt social interaction, working abilities, and other situations in adulthood.

The diagnostic process:

As we mentioned before, just because a child shows overactive behavior and impulsive tendencies does not mean the child should be diagnosed ADHD. An accurate diagnosis requires input from several different sources, including teachers and parents.

The professional making the diagnosis can be a social worker, pediatrician, child psychiatrist, psychologist or other knowledgeable professional from mental health fields or medicine. It is suggested that the parents inquire whether the professional has knowledge and experience regarding ADHD diagnosis.

The diagnostic process includes information provided by teachers and parents. A diagnosis based solely upon an office visit and professional observation may be highly inaccurate. In novel environments, with authority figures, and under unusual conditions, children with ADHD often do not display disruptive symptoms. Information from both parents is important. Information from teachers who know the student well is highly beneficial and many times essential. Behavior checklists are the most efficient tools used to gather information from parents and teachers regarding ADHD symptoms.

Along with information coming from home and school, the professional in charge of the final diagnosis will observe the child's behavior for more than one session. Additional testing materials may or may not be needed. Let us talk briefly about situations where additional testing may be needed.

Intellectual Evaluation:

Intelligence does not have anything to do with the occurence of ADHD. Children with these disorders may be highly intelligent or mentally retarded. Being intelligent does not rule out ADHD. However, intellectual level is related to behavior and should be considered when behavior expectations are developed. Because intellectual level is related to the therapeutic approach, the professional will want to know the intelligence potential of the child before developing therapeutic recommendations. Another reason why intellectual evaluation may be requested is when apparent intellectual deficiencies may be the underlying reason for the overactive and impulsive behavior. One more important reason for requesting intellectual evaluation may be the need to evaluate the presence of learning disabilities. Some ADHD children experience learning disabilities. Specific treatment for ADHD is not going to address a learning disability. In these cases, additional educational support has to be provided.

Neurological evaluation:

There is no evidence that ADHD is the result of brain damage. Brain damaged children may show ADHD symptoms, but this does not mean that children with ADHD have brain damage. This is why a neurological evaluation is not going to rule out or rule in the diagnosis of ADHD. A neurological evaluation may be recommended to rule out possible brain impairment. This possible brain impairment may accompany ADHD or may exist alone. This information may be of importance in overall treatment planning.

Other Evaluations:

Evaluation of diets has not demonstrated a connection with ADHD. However, the possible existence of food allergies contributing to or independent from ADHD may be present.

Treatment:

Treatment for ADHD children attempts to alleviate the disruptive effect of the symptoms. Treatment is not intended to "cure" the symptoms. As with many other handicapping conditions, ADHD usually lasts a lifetime and it is not curable. We attempt to control the adverse effects and provide these children with the needed tools to deal with job and social demands despite the presence of ADHD symptoms. No single treatment approach has proven to be sufficient to deal with all of the ADHD symptoms. Let us talk about the two approaches that, so far, have provided the most effective results. These are behavior/cognitive interventions and medication.

Behavior/Cognitive Interventions:

These interventions involve a set of procedures to be implemented to help counteract the adverse effects of ADHD. It is suggested that before any other approach is tried, including medication, behavioral techniques should be implemented. Following are brief comments regarding these techniques:

Consistency is one of the most key issues in behavior/cognitive interventions. Consistency means that once we set a rule at home such as "dinner time is 5:00 P.M.", it is expected that the children will be having dinner at 5:00 P.M. and not at 6:00 P.M. or 4:00 P.M.

Routines help to organize activities for ADHD children. These children tend to be very disorganized. Without routine this disorganization gets worse. Consistency means that when the mother says something such as "no TV before homework," the father is going to back this decision. If the father decides something different, this creates confusion in the ADHD child. At the same time, children learn that they can "play games" with parents. If they do not get what they want from one parent

they run to the other one. Situations like this usually end up in arguments between parents who blame each other for the inconsistent behavior in their child.

Consistency means that, as much as it is possible, we have to keep enforcing whatever we say we are going to do day by day. If the parent says no friends over between 4:00 P.M. and 6:00 P.M., this will be valid for every single day during the week (weekend routine may be defined separately). If the parent says no clothes on the floor before going to bed, the parent will enforce that direction every single day of the week.

Consistency means that, as much as it is possible, the same directions and instructions that the children have to follow at home will be enforced when they visit uncles, aunts, grandparents, and friends.

that the parents' behavior and reactions to the ADHD child's performance will be regulated by the preplanned program rather than by the parents' mood that particular day.

Single directions increase the chances for the ADHD child to comply with directions. Multiple directions such as "go to your room, pick up the clothes from the floor, put them in the laundry basket, and bring the basket to the basement" usually do not provide satisfactory results. The chances are that as soon as the child goes to his/her room, he/she will do something else, "forgetting" whatever you asked for.

Enforcing rules is very important. If you ask your ADHD child to bring his books to do homework and you decide to go to your room to do your own chores, chances are that your child will "forget" and do something else. Try to be available to enforce rules on a consistent basis.

CALVIN, I'D LIKE YOU TO PICK UP ALL THE STICKS AND FALLEN BRANCHES IN THE YARD, SO I CAN MOW IT.
WILL YOU PAY ME?

WELL... OK, I'LL PAY YOU A DOLLAR.
A DOLLAR? I WON'T DO IT FOR LESS THAN TWENTY-FIVE!!

IN A MINUTE YOU'LL DO IT FOR NOTHING, JUST BECAUSE I TOLD YOU TO.

..I'LL TAKE THE DOLLAR.
SMART KID.

Clear directions increase probabilities for compliant behavior. Unclear or vague directions such as "do not bother your brother" or "clean up your room" may not provide positive results. The ADHD child may decide that the little brother is bothered if he is pushed but not if he is tickled, then this child starts endless tickling. This child may decide that picking up toys and putting them under his/her bed is "cleaning." In both situations the ADHD child has to decide the real meaning of the direction because no specifics were provided.

Directions have to be clear and specific:

Some clear directions may be:

- Put your book on this table.
- Bring me your red pants.
- Put the dishes in the sink.
- Do your math problems.
- Hold your brother's hand.
- Watch TV in silence.

Some examples of unclear directions may be:

- Clean up your room.
- Do your chores.
- Do not play while eating.
- Be nice to your sister.

Directions in positive and specific terms usually avoid further difficulties. Saying "do not talk with your mouth full" does not prevent from "talking with a half-full mouth." Saying "do not scribble on the wall with your crayons" does not preclude "drawing nice pictures with color pencils." Better results may be obtained if you say "you can talk only when your mouth is empty" or "if you want to draw, use these papers; the walls are not for drawing."

With ADHD children the development of problem solving skills facilitates positive response to social demands. It is important to teach these children how to respond to peers, during play time and study time. Many of their disruptive reactions and awkward responses result from "not knowing better." Conversation about how to make and keep friends, how to respond to provocations for a fight, or invitations to play are important issues that ADHD children do not manage well.

Things I want to do today
between 9:00 - 11:00

1. Exersize with my mom
2. Play my nintendo tape
3. Go to store with mom to buy a nintendo tape
4. Play baseball with my friend
5. Go for a bike ride at the park
6. Go roller bladeing at the park
7. Come home and go in the pool
8. Play basketball
9. Go to dairy park to eat

Michael

BEST COPY AVAILABLE

Medication:

This is a very controversial topic not because medication has a high risk factor, but because it may be used inappropriately and opposed by people who, without much scientific knowledge, question its benefits. Medication for ADHD children presents risks similar to other medication in terms of side effects. Medication for ADHD is as safe as any other commonly used medication.

Studies show that the great majority of children taking medication for attention disorders experience significant improvement. A small group of children do not show much improvement, and an even smaller group show adverse reactions. For the last two small groups, changes in the type of medication or in the dose usually improve results. The benefits obtained by those who experience significant improvement are shown in the school and home settings. Studies indicate that these children increase attention span, reduce impulsive tendencies, improve peer interaction (as a result of decreasing disruptive behavior) and improve compliant behavior. (See References.) A parent guide to understanding the effects of Ritalin). However, secondary symptoms such as lying, stealing, intentional aggressive behavior, and intentional oppositional and defiant behavior are not directly affected by this medication.

Medication has to be prescribed by a physician. Teachers, psychologists, counselors, parents, and social workers are able to provide valuable information to the physician to help the physician prescribe specific medication and doses. However, only a physician can prescribe and monitor the side effects of medication.

The use of medication as a diagnostic tool, that is, to see if the child responds to medication to verify the diagnosis of ADHD is not a valid diagnostic method. Most people experience benefits from these medications in terms of attention span or alertness which does not mean that most people have ADHD.

Common medications in the treatment of ADHD are: Ritalin (generic: methylphenidate), Dexedrine (generic: dextroamphetamine), and Cylert (generic: pemoline).

Typical side effects such as head and stomach aches, sleeping problems, and others usually disappear after the first three weeks. If they last longer, consult your doctor.

Consultation with the prescribing doctor is recommended at least every other month to closely followup progress and side effects.

Finally, medication must be used as prescribed to be effective. Medications used for ADHD are generally fast acting and their effects last only a matter of hours. If medication is stopped, symptoms return. This is why medication represents only a small portion of the whole treatment. Relying only upon medication is a mistake. Medication should be accompanied with behavioral/cognitive interventions in such a way that by the time medication is discontinued, these interventions are going to take over in the process to overcome the disruptive symptoms of ADHD.

Things to remember:

- Not every overactive child is a hyperactive child. ADHD behaviors are not intentional. Do not take them personally.
- Rules, directions and a structured environment facilitate compliant behavior in ADHD. Punishment alone to correct these children does not provide positive results in the long run.
- Diagnosis and treatment require specialists in the field of attentional disorders.
- Treatment for attentional disorders is more a family treatment rather than an individual treatment.
- Treatment for attentional disorders helps to alleviate their disruptive effect. Treatment will not cure these disorders.
- Behavior/cognitive interventions should be the first treatment approach.
- Medication provides the opportunity for a more efficient implementation of behavior/cognitive interventions.

For additional information regarding ADHD, literature, and support groups contact your local CH.A.D.D (Children and Adults with Attentioon Deficit Disorders) Chapter. To obtain information regarding a CH.A.D.D. Chapter in your area, please call 305-587-3700.

References

Attention Deficit Hyperacticity Disorder: A Handbook for Diagnosis and Treatment.
-Russell Barkley, 1990, Guilford Press, New York, NY.

Management of Children and Adolescents with Attention Deficit–Hyperactivity Disorder.
-Ronald Friedman & Guy Doyal

The Hyperactive Child, Adolescent, and Adult.
-Paul Wender, 1987, Oxford Univ. Press, New York, NY.

The Difficult Child.
-Stanley Turecki & Leslie Tonner.

Your Hyperactive Child.
-Barbara Ingersoll, 1988, Doubleday, Garden City, NY.

A Parent Guide to Understanding the Effects of Ritalin.
-O. Villegas, R. Brozovich, & T. Harwood, 1992,
Oakland Schools, Waterford, MI.

Planning Good Days for Children with ADHD: Tips for Parents.
-O. Villegas, R. Brozovich, & T. Harwood, 1994,
Oakland Schools, Waterford, MI.

Does My Child Have Attention Deficit Disorder? How Parents Can Help in Diagnosis.
- R. Brozovich, T. Harwood, & O. Villegas, 1994,
Oakland Schools, Waterford, MI.

It is the policy of Oakland Schools that no person on the basis of race, color, religion, national origin or ancestry, age, sex, marital status, or handicap shall be discriminated against, excused from participating in, denied the benefits of, or otherwise be subjected to, discrimination in any program or activity for which it is responsible or for which it receives financial assistance from the U.S. Department of Education.

BEST COPY AVAILABLE